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Office and Emergency Room Violence

According to John Nicoletti PhD, a police psychologist and author of Violence Goes to School: Lessons Learned from Columbine (June 1989) and Violence Goes to College: The Authoritative Guide to Prevention and Intervention (October 2001), "Survivors of workplace violence have one characteristic in common: they were prepared for it, with responses and communication systems in place before the violence occurred."

"Surgeons and other physicians often live in a world of denial. They don't consider the possibility that their patients would become violent or that anything would happen in their office. So a lot of times, they're caught off guard. They have no real safety procedures set up and no way of notifying other people in the office that a violent act is occurring."¹

Violence in our local hospitals and offices does occur. We usually see brief reports of these incidents in daily newspapers. Major events such as the Xerox Co. shooting make headlines internationally. A manager of one of our major hospitals says, "Violence in our emergency room is not common, but we are seeing more of it." Data from our police departments about the incidence of violence in medical offices, hospitals, and emergency rooms is not available and is not being collected.

A study in the *Annals of emergency Medicine* found that violent events are frequent in emergency departments and that educational programs might reduce the number of events at least temporarily, but do not clearly reduce violence in the long-term.²

Despite the fact that we cannot prevent all violence in emergency rooms and offices, we must prepare for the possibility that it can happen:

- The prevalence of handguns and other weapons - as high as 25 percent* - among patients, their families, or friends. The increasing use of hospitals by police and the criminal justice systems for criminal holds and the care of acutely disturbed, violent individuals
- The increasing number of acute and chronically mentally ill patients now being released from hospitals without follow up care, who now have the right to refuse medicine and who can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others
- The availability of drugs or money at hospitals, clinics and pharmacies, making them likely robbery targets
- Situations and circumstantial factors such as unrestricted movement of the public in clinics and hospitals; the increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members; long waits in emergency or clinic

areas, leading to client frustration over an inability to obtain needed services promptly

- Low staffing levels during times of specific increased activity such as meal times, visiting times, and when staff are transporting patients
- Isolated work with clients during examinations or treatment
- Solo work, often in remote locations, particularly in high-crime settings, with no backup or means of obtaining assistance such as communication devices or alarm systems
- Lacking of training for staff in recognizing and managing escalating hostile or assaultive behavior
- Poorly lighted parking areas

The Occupational Safety and Health Administration (OSHA) has developed violence prevention guidelines for reducing workplace violence for healthcare workers. The *Guidelines for Preventing Workplace Violence for Healthcare and Social Science Workers* can be found in GOVDOC L 35.8:H 34/2, 1996. This related references can be found in the Hawaii Medical Library.

At the very least, you should form a plan for your own office or clinic. According to Dr. Nicoletti, attack notification measures are vital. Some offices and emergency rooms use a PA system. He strongly suggests not to use common codes for trouble. Under duress, people don't remember the codes. Clarity and brevity are necessary. He advises "shots are fired in the reception room," etc. Prompt notification of law enforcement agencies is obvious, but some telephone systems do not get right to 911. You may have to dial 9 first. Putting a sticker on each telephone will help: "Emergency 911" or "Emergency 9-911". Train all staff members to be aware of possible incidents; be knowledgeable about unusual behavior and be prepared for it.

Since the *other* 911, the September 11th terrorism attack, metal detectors are more commonly seen in public and private buildings. A study at the Vanderbilt University Medical Center in Nashville investigated patron (i.e. parents and relatives of pediatric emergency room patients) attitudes about metal detectors in emergency rooms. It concluded "fear that patrons will be disturbed or that the presence of a metal detector reflected negatively upon the institutions appear to be unfounded."³

Just as we are now preparing for biological and chemical terrorism, physicians should also prepare for office, emergency room and hospital violence.

References

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2. Fernandes, CM, et al. Violence E.D. Study group. *Ann Emerg Med* 39(1):47-55, 2002 Jan
3. Mattox, et al. *Ped Emerg Care* 16(3):163-5, 2000 Jan